



Allied Health Professions Supervision Policy

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Section 1 – Introduction

Supervision in health and social care has been endorsed for decades and is an essential component of safe and effective practice amongst health professionals, also supporting staff health and well-being (HCPC, 2022).

The supervisory process should promote and protect the best interests of staff and service users irrespective of diversity of experience, including all protected characteristics under equality legislation.

This policy was reviewed by the Equality and Human Rights Team with no perceived risk to warrant a full equality impact assessment.

Section 2 - Policy context

2.1 – Rationale

This policy has been formulated to ensure that AHP staff have a clear understanding of their own and the organisation's responsibility in relation to supervision, by outlining a set of underpinning processes and a framework for implementation. Although complementary, supervision is separate and distinct from line management and professional leadership.

This policy aligns with the principles set out in [Scotland's Position Statement](#) on Supervision for Allied Health Professions (NHS Education for Scotland, 2018).

Supervision supports the principles of clinical governance, ensuring the right person is doing:

- The right thing (evidence-based practice)
- In the right way (skills and competence)
- At the right time (in the person's journey)
- In the right place (location of treatment)
- With the right result (maximising health gain)

The Francis Report (Francis, 2013) highlighted the importance of ensuring staff groups are supported to deliver the best quality service to patients. Research by the Health and Care Professions Council (HCPC, 2015), found that lack of access to, or unwillingness to engage in supervision is linked to poor competences and staff disengagement, which in turn leads to poor care delivery. Supervision can identify small problems and address these prior to these escalating.

The NHSGGC Mental Health and Wellbeing Policy and Guidance (NHS Greater Glasgow and Clyde, 2015) highlights that it is the responsibility of all employees to support activities that enable good mental health and wellbeing. When implemented, this policy can support employees to utilise supervision as one activity that can support wellbeing at work.

The focus on quality, productivity and efficiency must be balanced by providing support and development opportunities for staff. The Healthcare Quality Strategy (Scottish Government, 2010)

makes a clear connection between staff engagement and enhanced organisational performance, linking staff experience and wellness with improved patient outcomes.

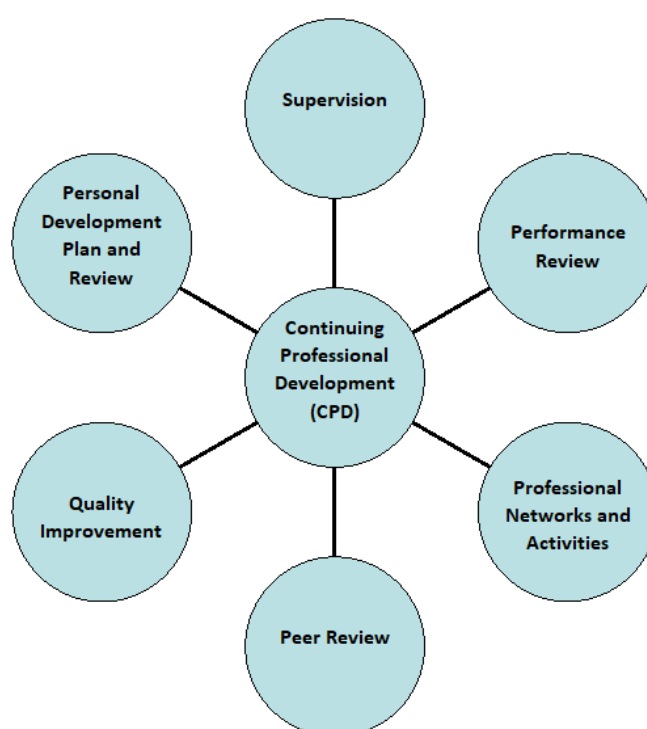
2.2. Definitions

Supervision

Whilst there is no single agreed definition of supervision, there are common purposes attributed to it (NHS Education for Scotland, 2018). Supervision is a required, accountable process which supports, assures and develops the knowledge, skills and values of a clinician, clinical groups or teams. It involves reflecting on the quality and effectiveness of practice, celebrating success and identifying any areas for improvement where needed. This process is supported and constructively challenged through discussion and reflection with a supervisor, enabling the supervisee to assume responsibility for their own practice and enhance patient protection, quality and safety of care. Supervision should be tailored to the supervisee's level of experience and development. Supervision should be led by the supervisee.

Supervision should be available to all AHP staff across the 4 areas of professional activity: - practice, professional, managerial and operational (NHS Education for Scotland, 2018). This is complementary to other organisational and operational support mechanisms in place for appraisal and performance management (see Figure 1.)

Figure 1. – Staff support mechanisms



Supervisor

The person using their knowledge and experience to facilitate structured reflection on practice within the context of supervision. Supervisors should have the skills and attributes required to facilitate a constructive supervisory relationship (Snowdon, et al., 2019). With regards to 'practice or clinical' supervision the supervisor should ideally be from the same profession, with experience in the same (or related) clinical area. However, all components of supervision may not necessarily be carried out by the same supervisor due to the nature of multidisciplinary teams (NHS Education for Scotland, 2018).

Supervisee(s)

Any member of AHP staff engaging in supervision, Band 2-8

Scotland's Position Statement (NHS Education for Scotland, 2018) takes the position that all AHP practitioners, irrespective of their level of practice or experience, should have access to, and be prepared to make constructive use of supervision. This policy recommends that supervision arrangements are in place for registered staff and Healthcare Support Worker staff, as highlighted in the Induction Standards for Health Care Support Workers (Scottish Government, 2009) and the Scottish Social Services Council (SSSC) Code of Practice for Social Service Workers and Employers (Scottish Social Services Council, 2024).

2.3 Purpose of Supervision

Effective supervision is an important component of clinical governance, supporting improvements in clinical practice through reflection and support of clinicians (Dawson, Philips, & Leggat, 2012).

Effective supervision occurs when an individuals' professional development is the focus. This is carried out by a skilled supervisor who can facilitate a constructive supervisory relationship, where the organisation's culture promotes an environment that facilitates both these factors (Snowdon, et al., 2019).

The literature demonstrates that when implemented effectively, the benefits to staff of regular supervision include:

- reduced risk of staff burnout (Martin, Lizarondo, Kumar, & Snowdon, 2021)
- reduced stress and anxiety (Rothwell, Kehoe, Farook, & Illing, 2021)
- reduced feelings of professional isolation (Ducat, Priya, Kumar, Burge, & Abernathy, 2016)
- help for clinicians to cope better with work stress to increase their level of confidence in their practice, resulting in a positive impact on patient care (Kuipers, Pager, Bell, Hall, & Kendall, 2013)
- enhancing professional practice
- improving quality of service offered to patients and carers
- having opportunity for safe, non-judgemental professional development associated with maintaining and developing the individual's excellence and independence in a particular role.
- enhancing working environments, job satisfaction and staff retention (Rothwell, Kehoe, Farook, & Illing, 2021)
- encouraging a supportive and safe environment for effective and meaningful supervision discussion to take place is key.

It is recognised that on occasion, conversations may lead to topics of discussion out with the remit and purpose of a supervision discussion. Should this occur, as a duty of care, supervisors are expected to refer matters of significant concern relating to practice, patient safety or health and wellbeing, through the appropriate channels, in line with workforce policies. Matters of significant concern from a supervisee must also be referred for consideration through appropriate workforce policies. For more information regarding confidentiality please see section. 3.4

2.4 Professional Body Guidance

The HCPC Standards of conduct, performance and ethics (HCPC, 2024) include several standards relating to supervision. Supervision being identified as a valuable component of professional practice, promoting safeguarding, continual professional development (CPD) and working in partnership with colleagues and people they provide care to. These standards ensure AHPs “practice safely and effectively while maintaining high professional standards of professional conduct” (HCPC, 2024).

Similarly, the HCPC Standards of continuing professional development (HCPC, 2017), recognise supervision as an important feature of CPD – how “registrants continue to learn and develop throughout their career, keep their skills and knowledge up-to-date and ensure they work safely, legally and effectively”.

The HCPC (2022) recognises that professional bodies produce their own guidance around supervision, therefore seeks specific advice from each of the AHP professions it regulates.

2.5 Differentiating Types of Supervision

AHP practice supervision, line management and professional leadership are separate and distinct processes which are important to differentiate.

AHP line management is a mandatory, hierarchical supervisory and supportive process wherein an individual staff member’s workload, clinical practice and operational performance are monitored.

AHPs should have access to AHP professional leadership support from someone of the same profession who can support them with issues relating to the specific scope of their practice, e.g. professional guidelines/practice, CPD and other profession-specific needs.

Cross-profession supervision

HCPC guidance (HCPC, 2022) suggests that supervisors can be from a different profession to the supervisee provided that they have the appropriate skills, knowledge and experience to conduct the supervision being requested.

When this happens, it is essential that supervisors take the time to understand any differences in professions/roles and to identify any limitations to the supervision they can provide. This may involve seeking advice and support from senior colleagues in the supervisee’s profession as appropriate. We would also expect supervisors to have received appropriate training and support, to provide the supervision required (HCPC, 2022).

Examples of how cross-profession supervision is used by AHP teams;

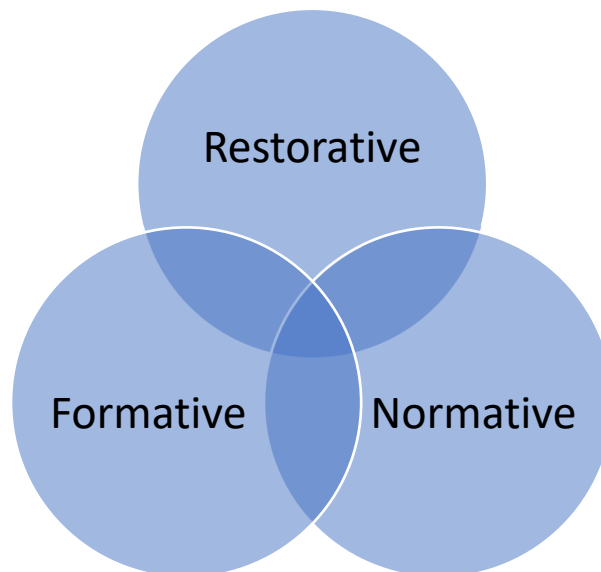
- where the supervisee works within a multidisciplinary team and there is the opportunity for the supervisor to be from another profession
- where the staff member is the only one from their profession within the team so regular uni-professional supervision cannot be offered
- where the staff member works within a highly specialist, or advanced practice role and specialist supervision particularly around clinical aspects may be better suited to another specialist professional from the clinical area, for example a medic or advanced nurse practitioners may provide specialist supervision for an AHP from the same area.

2.6 Supervision Model

Theoretical models for supervision are a way to organise and thereby structure an approach to supervision. Use of a model can facilitate interaction and ensure continuity. Proctor's model of supervision (cited in Clinical Supervision Toolkit (Helen and Douglas House, 2014)) is one of the most frequently cited supervision models in the literature (Figure 2). Proctor's model provides a useful way of thinking about the purpose and benefits of supervision and is one of the most widely recognised models amongst health care professionals.

Proctor's model (Figure 2.) identifies three main functions or elements of supervision: normative, formative and restorative.

Figure 2. – Proctor's Model



The focus on one or other of these functions or elements can vary according to the needs and values of the individual supervisee or group. This model is not prescriptive and should guide the supervisor and supervisee to develop across all or any of the three areas.

Restorative (Supportive)

Key words - supportive, building resilience, coping strategies

The restorative element is concerned with well-being, personal development and building resilience, by focusing on providing support, motivation and encouragement. This enables the supervisee to cope with the emotional aspects of their professional role, manage stress and distress and helps prevent burnout. The restorative element also enhances morale, establishes good working relationships and validates good practice.

Providing a safe environment allows honesty and reflection on emotional responses, identifying when further support may be needed, e.g. from Occupational Health.

Normative (Managerial)

Key words – Administration, Patient safety, Quality assurance, Professional standards

The normative element focuses on the managerial aspects to learning, maximising performance by enabling the supervisee to reflect on the quality, effectiveness and appropriateness of their practice. The supervisor works to support the supervisee's own awareness and sense of responsibility, including legal, ethical and professional requirements of their practice. The supervisor provides honest and constructive feedback, supporting practice and challenging when necessary.

Formative - (Learning)

Key words – Education and Professional development, Skills and knowledge, lifelong learning

The formative element focuses on the educational aspects of practice, with the continual formation of knowledge, skills, attitudes and abilities. The normative element supports personal and professional development, identifying further learning and development needs, thus encouraging and supporting lifelong learning and development.

Learning is achieved in supervision through support and guided reflection on practice.

2.7 Supervision Approaches

A variety of different approaches to the delivery of supervision are available. Groups of staff may identify a preferred approach or approaches from the list below which may result in more than one approach being employed. Where possible, supervisees should be given a choice of supervision approaches.

Regardless of which approach is selected, the following is required (Rothwell, Kehoe, Farook, & Illing, 2021):

- an open, supportive and safe environment
- establishing a supervisory relationship based on trust
- regular supervision with timely feedback
- training for supervisors

One to One (1:1)

Between a supervisor and supervisee. This is the most traditional approach to supervision. The supervisor may be equally or more experienced/knowledgeable than the supervisee, but will have skills in supervision.

Triadic approach

The 1:1 model is expanded to include a 3rd person. Triadic supervision is commonly used as an approach in counselling education programmes to give support and feedback to the supervisor (Lonn, 2014) For those supervisors who are new to this role, a second supervisor may help in this way too. This approach can also be applied in practice for 2 supervisees to have supervision with 1 supervisor. The presence of 2 supervisees can offer peer support and may enhance the quality of the session by bringing another perspective (Felton, Morgan, & Bruce, 2015).

Group approach

More than 2 supervisees participating in supervision from one supervisor. This may be appropriate where the group members share similar supervision needs which may have been identified in 1:1 sessions.

Peer Group approach

All participants offer mutual support through sharing, rather than receiving supervision from a single supervisor. A chairperson or facilitator should be clearly identified, to ensure that sessions remain constructive and allow all supervisees the chance to participate. This role would normally be rotational. Organisational support, facilitator training, group structure and planning for sustainability are critical factors for success.

Team approach

All supervisees who work together within a team, receive group supervision from one supervisor. This may be profession specific or a multidisciplinary team.

Network approach

This is similar to peer group support but where those involved do not work together on a regular basis.

Walk and talk

A more casual 1:1 approach, where supervisor and supervisee engage in supervision whilst walking outside. Patient sensitive information should not be discussed during this session, due to being unable to guarantee a confidential environment.

Virtual supervision

The use of technology to engage in supervision arose during the COVID-19 Pandemic. Many people prefer this approach due to its flexibility (e.g. no venue booking, and no travel time needed).

The use of MS Teams for virtual supervision session is the preferred platform.

Virtual supervision can offer the same benefits as face-to-face supervision and the use of cameras supports the maintenance of a good supervisory relationship, while recognising both parties may need to work harder to build rapport, trust and mutual respect via a virtual platform. It is recommended that the supervisee is afforded the choice of face to face or virtual supervision.

Section 3 – Processes

3.1 Identifying a supervisor

A trusting supervisory relationship is vital and so it is important that the following points be considered when identifying a suitable supervisor:

- The choice of supervisor will be made through negotiation and mutual agreement between the individual, their manager and the proposed supervisor
- The choice of supervisor will be based more upon appropriate skills, knowledge, cultural needs, expertise and accessibility, rather than relying on hierarchical status or clinical location
- Whilst an individual is entitled to decline any specific supervisor proposed, they cannot refuse all supervisors (Dimond, 1998).
- It is important to review the supervisory arrangement regularly as supervisee needs may change over time (NHS Education for Scotland, 2018) (see section 3.3).

3.2 Supervision Frequency

The frequency and duration of supervision sessions will vary according to the supervisee's situation. The **minimum** recommended number for AHPs is **6 sessions per year**, at regular intervals, with each session allocated **at least 1 hour**. This minimum applies to **all** AHP staff. One study found that clinicians who engage in a minimum requirement for supervision reported more effective supervision than those who did not (Snowdon, Millard, & Taylor, Effectiveness of clinical supervision of physiotherapists: a survey, 2015). Without the minimum requirement clinicians found it difficult to find time for supervision despite recognising its importance and value. Supervision should be flexible and available ad hoc if required (NHS Education for Scotland, 2018).

It is important to recognize that some staff may require more than the minimum. The required frequency and duration of supervision sessions should be negotiated on an individual basis, taking into account the supervisee's needs and circumstances (e.g. moving into a new role, taking on new responsibilities). This should then be agreed and specified in the Supervision Agreement.

Irrespective of whether the supervision session takes place in person or virtually, time should be afforded for preparation, either in advance or at the start of the session, as well as time afterwards for reflection.

A private space and protected time for supervision sessions is essential, regardless of whether this is face-to-face, or using digital technology. Both supervisor and supervisee should arrange appropriate venues, ensuring non-essential interruption can be avoided.

3.3 Record Keeping (documentation)

Record keeping (or documentation) in relation to supervision provides a means of governance for staff members and the organisation, and provides evidence that staff are participating in supervision.

Both supervisor and supervisee are responsible for ensuring that the required documentation is made available, completed, and kept up to date.

Required documentation

1. AHP Supervision Agreement
2. AHP Supervision Session Attendance Record*
3. AHP Supervision Session Summary

Suggested templates for these 3 documents are included in Appendices 1-3

***NHSGGC recommends the use of eESS to record attendance, providing evidence for audit and governance purposes. This may be problematic for some teams and services due to managerial structures. In the absence of this approach, teams and services must find an alternative way to provide evidence of supervision activity. Additional information on the use of eESS can be found in Appendix 4.**

1. AHP Supervision Agreement

The content of this agreement should be discussed and confirmed collaboratively between the supervisor and supervisee at an early stage. As described in Section 2.2 and 3.5, the supervisory relationship is key and should allow supportive, open and honest discussion, including negotiating what is included in the agreement. The agreement should be re-visited regularly, and at least once per year.

2. AHP Supervision Session Attendance Record

The supervisor and supervisee should jointly complete the record of attendance at each session. In group supervision, one supervisee is usually responsible for completing the attendance record, which includes names of all in attendance at each session.

3. AHP Supervision Session Summary

The session summary should be a collaborative process between supervisee(s) and supervisor. It should include the date of the session, key discussion topics and brief outcome and action points. For group supervision, only one supervision record is required. This can be circulated for all attendees.

A copy of each of the above will be signed and retained by the supervisor and supervisee, with a copy of the supervision agreement stored in the supervisee's personal file. If the supervisor does not have access to the supervisee's personal file, this should be sent to the supervisor's line manager for filing.

Desirable documentation

It is good practice for supervisees to keep a reflective account of their supervision sessions. This can be recorded and stored electronically using the [AHP professional portfolio](#) on TURAS, which provides ready to use templates. Although the supervisee can choose to use these reflections for

CPD/HCPC audit purposes, these records cannot routinely be requested for audit purposes and remain confidential to the supervisee, other than in exceptional circumstances, such as criminal proceedings or fitness to practice hearings (see section 3.4).

Electronic records

Supervisors and supervisees may choose to use electronic versions of any or all the above, rather than paper documentation. Like manual records, electronic records must comply with the guidance relating to the [Data Protection Act \(2018\)](#) given below under “Confidentiality within Supervision”.

Access to minimum documentation

Whilst the supervisee's right to confidentiality will be respected, NHSGGC will wish to monitor the implementation and effectiveness of supervision. Managers and auditors will require access to the following:

1. Supervision Agreement
2. Supervision Session Attendance Record

Supervision session summaries remain confidential and would only be accessed in exceptional circumstances noted e.g., in response to reports from the supervisor relating to unsafe practice and/or patient safety which the supervisee fails to address (see section 3.4). Similarly, it is not proposed that auditors access this documentation. They do, however, require access to evidence which confirms that supervision sessions have taken place i.e. The Supervision Session Attendance Record.

3.4 Confidentiality within supervision

All discussions within supervision are confidential and should only be disclosed to any outside party with the consent of both the supervisor and supervisee. **The only possible exception to this strict confidentiality would be where this is appropriate and justified, for example:**

- in response to reports relating to unsafe practice and/or patient safety which fail to be addressed
- disclosure relating to harm or risk to self or others
- contravention of law, professional code of conduct or local policy coming to light

It is important that the supervisee and supervisor have a shared understanding about confidentiality and when information might have to be shared. This should be agreed and recorded in the supervision agreement.

In the event of the supervisee/supervisor failing to take appropriate, corrective action, the supervisee/supervisor would consider whether disclosure is required in the “wider public interest”. If either party believes they are bound by ethical duty and/or professional code of conduct to report such a situation, they should advise the other that they intend to do so.

Confidentiality relating to patients or clients in supervision records must be maintained, except when the circumstances described above apply. Patients’ or clients’ names and details from which they could be identified must always be anonymised in the supervision record. Specific details regarding a patient or client’s care should be recorded only in that individual’s care-plan or case notes. Where supervision is focused on case discussions/review or application of clinical reasoning, patient/client records may be used to support this activity as part of the discussions, but no

identifying information can be included in the session summary or reflective accounts. Similar care must also be exercised regarding references to colleagues.

[The Data Protection Act \(2018\)](#) entitles any person to request access to any file (electronic or manual) which is designed to hold information in relation to them. However, anonymised entries such as “need to rehearse next session with patient X”, or “challenges working alongside colleague Y” would usually fall out with the Act.

3.5 Responsibilities

NHSGGC has a responsibility to ensure all staff are supported and encouraged to engage in supervision and that time to attend sessions is protected.

Supervisee(s) Roles and Responsibilities

- The supervisee is the focus of the supervisory relationship with openness, trust and understanding being developed (Lynch & Happell, 2008)
- Ensure the supervision session relates to Proctor’s model of supervision - Formative, Restorative and Normative (Helen and Douglas House, 2014)
- Identify areas to focus and reflect on and agree a plan with the supervisor
- To discuss freely any development needs, challenges and vulnerable feelings relating to their role
- Joint reflection between supervisee(s) and supervisor at end of session
- To reflect on feedback received during the session
- Implement agreed actions from supervision sessions
- Regularly evaluate effectiveness of supervision

Supervisor Roles and Responsibilities

- The supervisee is the focus of the supervisory relationship with openness, trust and understanding being developed (Lynch & Happell, 2008)
- Ensure the supervision session relates to Proctor’s model of supervision - Formative, Restorative and Normative (Helen and Douglas House, 2014)
- Create a safe space
- Agree areas of focus and reflection with supervisee/supervisees
- Recognise and reinforce examples of good practice
- Constructively address any negative values with an open and honest discussion
- Recognise and reflect own competencies as a supervisor and signpost supervisee to specialist help or advice as required
- Act appropriately regarding any unsafe, unethical or illegal practice
- Provide honest feedback
- Encourage reflection
- Regularly evaluate effectiveness of supervision

3.6 Training and Skills for Supervisors and Supervisees

Supervisees

Supervisees as a minimum should have

- An understanding of the concept of supervision and the functions that supervision serves (i.e. formative, restorative and normative)
- Time and space to explore what supervision can mean to them
- Ability to participate in effective supervision as a supervisee in line with the policy
- Negotiate mutual agreement
- Participate in structured approach to supervision (prepare, reflect and review ongoing development)
- Document and act upon outcomes of supervision

Though a tailored approach to training is encouraged, all supervisees are recommended to complete sessions 1 and 2 of the [Allied health professions \(AHP\) supervision education sessions | Turas | Learn \(nhs.scot\)](#), and register to attend Session 3 (details available from the NHSGGC AHP Practice Education Team - ggc.ginhahpepl@nhs.scot).

Supervisors

Supervisors should not assume that professional skills and experience are the same as facilitation skills, however many of the skills are transferable from practice. A lack of training in supervision can lead to ineffective supervision (Rothwell, Kehoe, Farook, & Illing, 2021). Supervisors should reflect on their own facilitation skills to direct their own training, but as a guide, supervisors should have

- Effective listening skills
- Cultural awareness
- Ability to help supervisees problem solve
- Ability to provide and receive feedback

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Other Resources

Value Based Reflective Practice

Values Based Reflective Practice, otherwise known as VBRP®, is a model which has been developed by NHS Scotland.

VBRP® can be used by anyone working in health and social care and is applicable across all disciplines and professional groups. VBRP® uses the principles of reflective practice to enable practitioners to understand and recognise their personal and professional value and by doing so supports them in delivering safe, effective and person-centred care. VBRP® principles can be utilised in supervision to support and structure reflective discussions.

Further information is available via this link - [Values based reflective practice \(VBRP®\)](#)

Staff Support in NHSGGC

Spiritual Care and Chaplaincy Service - NHSGGC

Staff Listening service

Available to any member of staff for support with work or personal life

Telephone line is open 9am-10pm, 7 days a week

Call Switchboard and ask for the staff listening service

NHSGGC AHP Supervision Policy Revision Group Members

Jane Dudgeon – Policy Lead/Chairperson

Becca Adams – Physiotherapy

Yvonne Allan – Staff Side Representative, Unite Union

Shona Ballenytne – Occupational Therapy

Gillian Beaton – Speech and Language Therapy

Laura Brady – Prosthetics

Dawn Buchan – Orthoptics

Sharon Dempsey – Administrative Support

Catherine Exposito – Podiatry

Laura Fraser-Rae – Therapeutic Radiography

Jill French – Practice Development, Physiotherapy

Nicola Greenwood – Practice Development, Podiatry

Andrea Gillespie – Practice Development, Occupational Therapy

Barry Johnstone – Practice Development, paediatric Physiotherapy

Graham Johnstone – Diagnostic Radiography

Tracy MacMillan – Art Psychotherapy

Anne Martin – Orthotics

Sarah-Jane Porch – Human Resources

Dorothy Rae – Occupational Therapy

Jillian Rennie – AHP Practice Education

Karin Russell – Practice Development Dietetics

Gordon Wilson – Staff Side Representative, Royal College of Podiatry

Appendices

Appendix 1- Supervision Agreement

NHSGGC AHP Supervision Agreement

We have read and agree to our rights and responsibilities as outlined in the NHSGG&C AHP Supervision Policy

Signature	Date
Supervisee:	
Supervisor:	
This is an agreement for: 1:1 supervision Group supervision Other	
The choice of Supervisor has been mutually agreed: Yes No	

Frequency of sessions	Min 6 per year	Duration of session	No less than 60 mins
Ways of Working			
Code of Conduct	We agree to abide by the HCPC and our individual professions Code of Conduct/Ethics		
Respect	We agree to show respect to one another		
Punctuality	We agree to be punctual		
Accountability	The supervisee is accountable for their own practice and decides what to bring to supervision		
Responsibilities	Agenda is set by the supervisee unless otherwise agreed supervisee and supervisor will come prepared		
Note-taking	The supervisee will keep notes which can be shared with their supervisor The supervisee and supervisor will keep a record of the sessions		
Cancellations	We agree to give notice of our non-attendance in advance, quickly re-arranging the session.		
Any other information			

supervisor name..... supervisee name

Copy to be kept by supervisee, supervisor and stored in personal file/in a shared drive

Appendix 2 – Attendance Record

NHSGGC AHP Supervision Attendance Record

[illegible]

Appendix 3 – Supervision Summary

NHSGGC AHP Supervision Summary

Supervisee name: _____ Date _____

Supervisor name: _____

Possible areas for discussion:

Formative Functions – promoting development of the supervisee’s clinical skills and knowledge

1. Professional development
2. Professional issues

Restorative Functions – wellbeing, recognises effects of work, and stresses upon the supervisee

3. Time management
4. Personal issues which may impinge on work
5. Dealing with stress

Normative Functions – ensuring safe working within frameworks for practice, HB organisational and professional standards

6. Work needs and responsibilities
7. Resource / Budget management
8. Other issues

Area(s) discussed	Summary Outcome	Actions	Whom	When	Next session

Appendix 4 – Using eESS to record supervision attendance

The following information describes the Standard Operational Procedure (SOP) for the use of eESS to schedule, record and monitor supervision sessions and attendance

NHSGGC AHP Supervision - eESS – Managing Supervision Sessions

SOPs available via this link - [eESS National Team website](#) under Learning Management Administrators section.

Whoever will be setting up the sessions and inputting attendance will require access to:
NHSS Learning Manager Administrator
OBIEE-Dashboard-Signon

Set up

On NHSS Learning Management Administrator

Select: Catalog Administration

>NHS Scotland

>SG999 NHS Greater Glasgow & Clyde

>Staff Governance

>GGC AHP Podiatry Supervision

GGC AHP Podiatry Supervision (Instructor Led) in boxes to the right, select **Classes**

Create Class

General

Title eg. GGC AHP Podiatry Supervision

Training Centre select venue

Location will autofill with location code when Training Centre complete

Status Normal

Schedule

Start date - date of session

End date - date of session

Start time - time of session start

End time - time of session end

Administration

No changes required

Enrolment

Enrolment start date - date of set-up

Enrolment end date - one week before session

Minimum attendees eg.4

Maximum attendees eg.20

Restricted ✓

Apply

Appendix 4 Contd. – Using eESS to record supervision attendance

Return to Catalog

Select Classes

Select Class (eg. GGC AHP Podiatry Supervision 27-03-24)

Select Enrolments (Left hand column)

Add Single Enrolment

General

*Enrolment Status Requested

Additional Information

No changes required

Learner Details

Last Name Does not search well on Last Name. **Use spy glass** and change Search By from Last Name to Full Name (surname, forename) or Email address

After first class has been enrolled you can use:

Add Bulk Enrolments

Copy Learners

Search

Copy From Class

*Class select spy glass

Text box opens: Search By Title e.g. GGC AHP Podiatry Supervision

Select required learners ✓

Add

Apply

Following initial set up, subsequent sessions of the same format can be set up by using copy & paste function. Staff can be enrolled using another copy & paste.

If you have multiple classes in the same format you can copy the class and rename it

After the session access the system to record attendance. There is a list of options for recording reasons for non-attendance.

An attendance report can be seen, and exported if required, on the OBIEE dashboards.